



# Summary of Dental Benefits 2023–2024 Plan Year

Please see Plan Handbook for details.



Dental	Premier Plan 1 <sup>1</sup>	Premier Plan 5 <sup>1</sup>	Premier Plan 6	Exclusive PPO – Incentive Plan <sup>1</sup>	Exclusive PPO Plan	Kaiser Dental Plan	Willamette Dental Plan
Network	Delta Dental Premier	Delta Dental Premier	Delta Dental Premier	Limited Network Plan – Delta Dental PPO <sup>2</sup>	Limited Network Plan – Delta Dental PPO <sup>2</sup>	Limited Network Plan – Kaiser Permanente Facilities <sup>2</sup>	Limited Network Plan – Willamette Dental Group Facilities <sup>2</sup>
Dental Office Visit Copay	N/A	N/A	N/A	N/A	N/A	\$20 <sup>3</sup>	\$20 <sup>3</sup>
Benefit Maximum	\$2,200 <sup>4</sup>	\$1,700 <sup>4</sup>	\$1,200	\$2,300 <sup>4</sup>	\$1,500 <sup>4</sup>	\$4,000 <sup>4</sup>	N/A
Deductible	\$50	\$50	\$50	\$50	\$50	N/A	N/A
<b>Preventive &amp; Diagnostic Services – Deductible Waived for Preventive &amp; Diagnostic Services on Delta Dental Plans<sup>6</sup></b>							
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year <sup>6</sup>	70% + 10% each Plan Year <sup>6</sup>	100% <sup>6</sup>	100% <sup>6</sup>	100% <sup>6</sup>	100% <sup>6</sup>	100%
<b>Restorative Services</b>							
Routine fillings, inlays and stainless steel crowns	70% + 10% <sup>1</sup> each Plan Year	70% + 10% <sup>1</sup> each Plan Year	80% <sup>1</sup>	70% + 10% <sup>1</sup> each Plan Year	90% <sup>1</sup>	100% <sup>3</sup>	100% <sup>3</sup>
<b>Simple Extraction</b>							
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	100% <sup>3</sup>	100% <sup>3</sup>
<b>Oral Surgery</b>							
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	\$50 Copay <sup>3</sup>	\$50 Copay <sup>3</sup>
<b>Periodontics</b>							
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	100% <sup>3</sup>	100% <sup>3</sup>
<b>Endodontics</b>							
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	\$50 Copay <sup>3</sup>	\$50 Copay <sup>3</sup>
<b>Major Restorative Services</b>							
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70%	50%	70% + 10% each Plan Year	80%	\$250 Copay <sup>3</sup>	\$250 Copay <sup>3,5</sup>
Implants	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	50% <sup>3</sup> (limit of 4 per lifetime)	Implant surgery up to \$1,500 calendar year maximum <sup>5</sup>
<b>Other covered services</b>							
Occlusal guards (night guards)	50% up to \$250 max, once every 5 years	50% up to \$250 max, once every 5 years	50% up to \$250 max, once every 5 years	50% up to \$250 max, once every 5 years	50% up to \$250 max, once every 5 years	90%, once every 5 years	100% once every 2 years
Athletic mouth guards	50%	50%	50%	50%	50%	90%	\$100 Copay <sup>3</sup>
Nitrous Oxide	50%	50%	50%	50%	50%	\$0 copay (Age 12 & Under) \$25 copay (Age 13 & Up)	\$15 Copay <sup>3</sup>
<b>Fixed and Removable Prosthetic Services</b>							
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	\$100 Copay <sup>3</sup>	\$100 Copay <sup>3,5</sup>
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	\$250 Copay <sup>3</sup>	\$250 Copay <sup>3,5</sup>
<b>Orthodontics</b>							
Orthodontic Treatment	80% to \$1,800 lifetime max	80% to \$1,800 lifetime max	NO ORTHO COVERAGE on this plan	80% to \$1,800 lifetime max	80% to \$1,800 lifetime max	\$2,500 Copay + \$20 per visit	\$2,500 Copay + \$20 per visit

1 Under Delta Dental Plans 1 and 5, and Exclusive PPO - Incentive Plan benefits start at 70% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year.

2 Services performed by providers outside the limited network are not covered unless for a dental emergency.

3 Office visit copayment applies at each visit, in addition to any plan copayments for services.

4 Preventive care and orthodontia do not accrue to this maximum.

5 Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit under the Willamette Dental Group plan.

6 Preventive services will not accrue towards the plan benefit maximum.

**This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.**